

Living and Dying Well

Keeping the law safe for sick and disabled people

Autonomy and Assisted Suicide



By Professor Onora O'Neill

We reproduce here, with permission from the author, the text of an address given on 30 June 2010 by Professor Onora O'Neill at a symposium on the ethics of assisted suicide held at the Royal Society of Medicine in London. Onora O'Neill writes on ethics and political philosophy, with particular interests in international justice, the philosophy of Immanuel Kant, questions of bioethics and conceptions of accountability and trust. She sits in the House of Lords as a Crossbencher (Baroness O'Neill of Bengarve), is a former President of the British Academy and teaches philosophy in Cambridge

Living and Dying Well is a public policy research organisation established in 2010 to promote careful analysis of the issues surrounding the subject of 'assisted dying' - the current euphemism for physician-assisted suicide. Living and Dying Well takes the view, based on the evidence, that legalisation of 'assisted dying' would pose serious risks to public safety and that debate needs to focus on rigorous analysis of the evidence rather than on campaigning spin.

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1. Introduction

I have been asked to talk about autonomy and assisted suicide and have taken my brief quite narrowly, although the arguments I shall offer have wider implications.^[1] The central problem for any attempt to legalise assisted suicide is that of drafting legislation which reliably ensures that those who do not seek to die, and in particular do not seek assistance with suicide, are not killed. Legislation that fails to draw a very clear distinction could endanger those who do not wish to die, and could provide a cover for unlawful killing: for that is what is at stake.

The most popular way of trying to draw the necessary distinction is to restrict the lawful assistance of suicide to cases in which an individual's choice to die, and specifically to seek assistance with dying, reflects **individual autonomy**. The only other argument of comparable popularity for permitting assisted suicide appeals to the idea that in difficult cases a person might be 'better off dead' — however, this judgement may be hard to substantiate and, unless linked to some account of individual autonomy, would also permit involuntary euthanasia. So far as I can tell, very few, if any, other arguments for legislation to make assisted suicide lawful are even being explored, let alone getting a friendly reception. For example, very few, if any, people think that assisted suicide should be made lawful because it would reduce world population, or save NHS costs, or preserve the size of inheritances, or even because it would reduce the amount of pain suffered. By themselves, *all* of these lines of thought would also support involuntary euthanasia, and are seen as suspect.

To find out whether appeals to respect individual autonomy provide good reasons for legislating to make assisted dying lawful, we need to understand what is meant by individual autonomy. This is much harder than one might imagine. Conceptions of autonomy have a long history, but the conceptions of individual autonomy that current discussions invoke are surprisingly different from earlier accounts of autonomy, and relatively new. So I begin with a potted history.

2. A Potted History of Autonomy

Jurisprudential Autonomy

The original use of the term autonomy was **jurisprudential**. The ancient Greeks contrasted colonies, whose laws were made for them by their mother cities, with *self-legislating* or *autonomous* cities that were not colonies, but rather made their own laws. Autonomous cities were politically independent. This political or constitutional use of the term *autonomy* is still current. It is quite different from contemporary understandings of individual autonomy, and the Greeks would not have spoken of individuals (who do not make laws at all) either as autonomous or as lacking autonomy.

Kantian Autonomy

The term *autonomy* famously acquired a quite different and more abstract sense in the

writings of Immanuel Kant in the 18th Century, which remain much respected — and much misunderstood. Kant classifies principles, rather than individuals, as autonomous — or otherwise.

He characterises principles as autonomous if they and the reasons for them could be adopted by all, rather than assuming deference to some supposed authority of limited scope, whether Church or State, ideology or preference. Kant, too, does not speak of individuals (who do not make laws at all) as autonomous, or as more or less autonomous. Rather he describes law-like principles that could be adopted by all for reasons that all could follow as autonomous, and other principles that can be adopted only by those who defer to some other supposed authoritative power or standard as heteronomous (i.e. reflecting the *law of another*).

As Kant sees it, human beings can choose to act on autonomous principles, whose authority is not derived from arbitrary sources that some reject; but they do not always do so. Reasons for acting on autonomous principles can be given to each and to all. By contrast, reasons for acting on heteronomous principles will carry weight only for those who defer to some preferred authority or standard – be it Church or State, ideology or preference.

Kant's account of **principled autonomy** is in my view relevant to current debates only because his authority is often, but spuriously, invoked by contemporary liberal advocates of the quite different 20th Century conceptions of **individual autonomy**.

Individual autonomy

Individual autonomy became prominent in public discussion following World War II, first in psychological and philosophical literature (often influenced by existentialist writings). It became a staple component of the revival of liberal political thinking in the 1980s, and has now penetrated far and wide into popular culture. Individual autonomy is generally seen as some form of individual independence, which is often, but not always, thought of as desirable.

3. Questions about Individual Autonomy

Appeals to the importance of developing, respecting and securing individual autonomy are ubiquitous in contemporary life. A lot of discussions address *empirical* questions, such as 'How can we develop autonomy in children?'. I leave these questions aside.

For present purposes we need to focus on *normative* or *practical* questions about individual autonomy, and there are lots of them. When and why should we respect individual autonomy? Does respect for individual autonomy demand a minimal State that legislates sparingly in order not to infringe individual autonomy, and in particular does not regulate action 'between consenting adults'? What might we lose sight of by asking which laws are needed to respect individual autonomy, rather than asking more broadly which laws would be effective, or just, or socially valuable?

For example, we might think – many do – that an autonomous decision to commit

suicide should be respected. And we might think – some do – that, if we should respect decisions to commit suicide, we should also make it lawful to assist others in committing suicide, provided those whom they help to die choose to do so autonomously. Yet we might also think that the influence that one person can have over another would make legislation permitting assisted suicide very risky.

I do not think that it is likely that we can address practical questions about assisted suicide, or frame adequate legislation, unless we are clear about *which* forms of individual autonomy should be required for assistance with suicide to be permissible, and would have to be embodied in any legislation making it lawful. Unfortunately there is very little agreement about what individual autonomy amounts to, and even less about the way in which respect for individual autonomy should be embodied in legislation that bears on assisted suicide. The problems are not peculiar to decisions about assisted suicide.

4. Autonomy in Contemporary Ethics

There is unfortunately radical disagreement about what individual autonomy amounts to, which has remained unresolved for over two decades. Consider two standard accounts summarising the range of views taken of individual autonomy in the late 80s:

"[Individual autonomy has been seen as] Liberty (positive or negative)... dignity, integrity, individuality, independence, responsibility and self-knowledge... self-assertion... critical reflection... freedom from obligation... absence of external causation... and knowledge of one's own interests... The only features that are held constant from one author to another are that autonomy is a feature of persons and that is a desirable quality to have".^[iii]

A second list, with little overlap with Dworkin's, can be found in a standard work on informed consent, which claims that autonomy is variously 'associated' with: "...privacy, voluntariness, self-mastery, choosing freely, the freedom to choose, choosing one's own moral position and accepting responsibility for one's choices".^[iii]

This variety was noted over 20 years ago and remains a feature of current public and popular debate about individual autonomy.

5. Meer Sheer Choice vs. Reflective or Reasoned Choice

It is, I think, virtually impossible to provide a systematic taxonomy of conceptions of individual autonomy, but it is possible to identify a minimal conception. **Minimalist** views of individual autonomy equate it with mere sheer choice, so count all choosing as autonomous choosing.^[iv]

Non-minimalist views see autonomous choice as choice that meets one or more of a number of additional, more demanding standards. On various accounts individual autonomy may be seen as choice that is *informed*, or *fully informed*, or *reasoned*, or *reflective*, or *endorsed* by other choices or *authentic* – or meets some of a gamut of other standards. Non-minimalist views of individual autonomy do not count any old

uncoerced choice as autonomous. Only choosing that meets the favoured additional standard or standards is to count as autonomous.

The gap between the thought that **mere sheer choice** counts as an exercise of individual autonomy and other more demanding conceptions of individual autonomy has produced endless intractable problems for medical practice.

On minimalist views of individual autonomy, respect for it is simply respect for patient choice — including choices based on lack of understanding or irrational fears, and choices that will endanger health and life. Anything else is seen as unacceptable paternalism. (In practice, professionals can mitigate the possibly disastrous effects of blanket respect for patient choice which a minimal view of individual autonomy supports both by restricting the choice set to professionally approved options and by deeming some patients incompetent to consent).

Nevertheless, even those who deploy a minimal conception of individual autonomy do not argue for respecting *all* choices. They mostly think that autonomous choice may be restricted for quite a lot of reasons, and in particular to prevent harm or risk of harm to others (J. S. Mill's harm principle). More interestingly, even those who ostensibly think we should respect even minimally autonomous choices often think we *should* legislate against *certain* activities between consenting adults, such as duelling or cannibalism, even where such activities are (at least) minimally autonomous for both parties.

6. Non Minimal Autonomy in Medical Ethics.

On non-minimalist views of individual autonomy, patient choice is to be respected only where it meets the favoured **additional** standards. Here endless debates about those **additional** standards begin. Should we respect patient choices only if they are informed? Does that mean that we should respect them provided relevant information has been given? If so, how much information must be given? And must the relevant information be understood? What if the information is cognitively demanding? Is it acceptable to require very ill patients to make cognitively taxing judgements and exercise non-minimal forms of individual autonomy? Is rejection of medical paternalism perhaps a mask for callous treatment of vulnerable patients? Are demands for patient autonomy a sad consequence of a need to lay off liability for medical injury by seeking pretence of detailed consent, even when patients are not genuinely competent to provide it?^[vi]

I remind you of these debates because they seem to me pertinent to any attempt to reach a view on legislation on assisted suicide on the basis of appeals to individual autonomy.

7. Individual Autonomy and Assisted Suicide.

If autonomy is taken minimally as a matter of mere sheer choice, then a claim that assisted suicide should be legalised in order to respect individual autonomy would mean that any choice to die — even one that reflects momentary whim, clinical depression,

false beliefs, or deference to others — should be respected. I doubt whether such positions have serious supporters.

But, if autonomy is **not** taken minimally and is not equated with mere sheer choice, then legislation to make assisted suicide lawful can only be justified by showing *why some specific non-minimal conception of individual autonomy should command attention and respect and be enshrined in legislation.*

This, I think, has been recognised *in part* in the Bills to legalise assisted suicide that have come before and been rejected by the House of Lords. These Bills typically have sought to include what are spoken of as 'safeguards' to ensure that a choice to die indeed reflects more than a minimal conception of individual autonomy, that might reflect momentary desire, lack of comprehension or lack of information. The difficulties lie in specifying clearly the form or degree of individual autonomy that should be required for this irrevocable choice to be lawful.

The justification for some proposed 'safeguards' is relatively easy to understand. For example, a requirement that there be a period of delay between an initial decision to request help to commit suicide and being helped to die is one safeguard for those with fluctuating or momentary desires to die: they are protected from the implementation of a choice which they might have rescinded, but if dead could not rescind. A requirement that the process for permissible assisted dying involve more than one doctor also offers *some* protection against its being based on misinformation or reflecting undue influence. It is doubtful, however, whether legislation can specify all the criteria that may be important.

8. The Nub of the Question

Incorporating a few 'safeguards' into legislation cannot, I believe, address the real difficulty of protecting patients (or others) against the consequences of choices that are not well grounded being visited upon them. A convincing non-minimalist account of individual autonomy has to take account of **many** ways in which individual autonomy may be limited. And here, I believe, our debates remain wholly inadequate.

Much popular coverage of assisted suicide has been marred by reliance on two assumptions that obstruct clear thinking.

The first assumption is a tendency to think mainly about individual cases that are so miserable that we are tempted to feel that anything must be an improvement. But, of course, legislation has to be framed to be safe for all citizens, not tailored for hard cases while risking the lives of others. Unless we can reliably specify the cases for which the legislation is intended, it will not be feasible to legislate. We can only legislate safely if we can reliably pick out the adequately autonomous patient (whatever that may mean) from patients whose choice is not adequately autonomous. Thinking about hard cases is not enough unless we can find clear distinctions between those cases and others.

A second assumption which mars these debates is that the favoured image of the autonomous patient is often coupled with another stereotypical figure, namely the

wholly compassionate relative, friend, carer or physician. But realities are more complex. Even the most loving families and friends may be greatly burdened by caring for a very ill person, not to mention impoverished. Even compassionate professionals are unlikely to be wholly or solely compassionate. Compassion is often, and understandably, mixed with frustration and even anger, and even with hopes and interests in another's death.

How are we to tell which requests for help to commit suicide express robust individual autonomy and which do not? How can we tell which choices express compliance with the (spoken or unspoken) desires of burdened carers and relatives, or of expectant heirs, whose compassion may be limited? How are we to tell which families and professionals are 'wholly compassionate'?

If we are to draft safe legislation to make assisted suicide lawful, we would need to find a way of ensuring that requests for help do not reflect either momentary despair or clinical depression, or weary compliance with, indeed deference to, the desires of relatives, carers, and professionals. Even deferential and frightened choices are choices, so minimally autonomous.

In a world of idealised wholly autonomous patients, and of wholly selfless and compassionate families and professionals, legislation providing for assisted dying might, if ethically acceptable, not be risky. But we do not live in that world, and I doubt whether we can draft legislation that is safe for human beings with their full variety of situations and dependence on one another. The philosopher Bernard Williams was, I think, right to suggest that 'we should not put too much weight on the fragile structure of the voluntary'.^[vi]

Footnotes

- i. In particular, they are relevant to legislation that seeks to make any form of voluntary euthanasia lawful, even where the patient takes no part in the initiation of death so that it is not strictly assisted suicide
- ii. Gerald Dworkin *The Theory and Practice of Autonomy* 1988, 6. Even the points he thinks agreed are disputed. As noted, autonomy is not always seen as a feature of persons, and it is not thought generally desirable by many who are concerned with virtue and character.
- iii. R. Faden and Tom L. Beauchamp *A History and Theory of Informed Consent*, 1986, 7.
- iv. For more detail see Onora O'Neill *Autonomy and Trust in Bioethics*, Cambridge University Press, 2002.
- v. These and related questions are discussed in Neil C. Manson and Onora O'Neill *Rethinking Informed Consent in Bioethics*, with Neil Manson, Cambridge University Press, 2007
- vi. Bernard Williams *Ethics and the Limits of Philosophy*, Fontana, 1985.

